

# Charitable Health Care Provider Agreement

## *For Independent Providers*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last

License or Registration Number: \_\_\_\_\_ Profession (MD, RN, DDS, etc.): \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_  
Street Address

\_\_\_\_\_ Phone Number: \_\_\_\_\_  
City State Zip

Email Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_

My signature on this agreement constitutes my intention to provide care to medically indigent patients. I understand that in order to be considered gratuitous, I may not charge the patient or individually submit a claim for those patients with public or private insurance.

Nothing in this agreement waives my right to bill insurance or an individual patient for services provided when that care is not provided as part of my participation in the Charitable Health Care Provider Program.

***I understand it is my responsibility to maintain patient records for services I provide as a Charitable Health Care Provider and that I must:***

- 1. determine that individuals seen as part of my participation in the Charitable Health Care Provider Program are medically indigent; and***
- 2. submit an annual activity report to KDHE (KAR 28-53-1).***

I agree that failure to fulfill any of these duties will result in cancellation of the agreement by the Secretary of the Kansas Department of Health and Environment to serve as a charitable health care provider.

\_\_\_\_\_  
Provider Signature Date

\_\_\_\_\_  
Susan Mosier, MD, Secretary Date  
Kansas Department of Health and Environment

**If a charitable health care provider is sued by the recipient of care, they must request representation from the state in writing within 15 days after service of process or subpoena (KSA 75-6108(e)). Indigent health care clinics, their employee(s), or charitable health care providers served with a summons or petition should immediately contact the Kansas Attorney General's office at 785-296-2215.**